DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3495
FAX: 605-773-5246
WEB: dss.sd.gov

DSS
Strong Families - South Dakota's Foundation and Our Future

OUT OF STATE PRIOR AUTHORIZATION REQUEST FORM

Form must be submitted with medical records to support out of state services.

NOTE: ALL FIELDS ARE REQUIRED

Date:	**State:** Select State	
GENERAL INFORMATION		
Choose Service Type: (Select all that apply) ☐ Inpatient ☐ Outpatient ☐ Physician		
Specify Facility/Clinic Name:		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Procedure Code(s):	**Quantity:**	
Procedure Description:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:**	**Sex:** ☐ M ☐ F
Last Name:	**First Name:**	
PROVIDER INFORMATION		
Referring Provider Name:		
Referring Provider NPI:	**Referring Provider Taxonomy:**	
Address:		
Point of Contact Name and Title:		
Fax:	**Phone:**	
Note: The determination notice will be sent to the listed Point of Contact.		
Accepting/Servicing Provider Name:		
Accepting/Servicing NPI:	**Accepting/Servicing Taxonomy:**	
Fax:	**Phone:**	

EXPLANATION OF PROBLEM: Provide an explanation of the particular problem resulting from the diagnosis which relates to this prior authorization request.

IS THE ACCEPTING PROVIDER ENROLLED WITH SD MEDICAID? ☐ YES ☐ NO

IF THE ACCEPTING PROVIDER IS NOT ENROLLED, ARE THEY WILLING TO ENROLL WITH SD MEDICAID? ☐ YES ☐ NO

ARE THERE ADEQUATE SERVICES AVAILABLE TO MEET THESE NEEDS IN SD OR A CLOSER LOCATION TO SD? ☐ YES ☐ NO

IF YES, WHERE:

IF YES, PLEASE PROVIDE AN EXPLANATION ON NECESSITY FOR SERVICES AT THIS LOCATION:

HAS THIS RECIPIENT BEEN SEEN BY THE SERVICING PROVIDER BEFORE? ☐ YES ☐ NO

IF YES, WHEN?

FOR WHAT PROBLEM?